



2005/2006 YABL SEASON

PARENTS, PLAYERS & COACHES

The Abe Montoya Recreation Center would like to welcome you to the Young American Basketball League Season. Please read and sign the following:

ABSOLUTELY NO REFUNDS

If for any reason your child cannot participate the \$50.00 will be used for the league. All participants **MUST** follow rules and regulations of the Recreation Program. If a Participant breaks the rules, he or she may be suspended from any of the programs.

Clerk Signature

Amount Paid check #

Parent Signature

Date

Child Name

Previous Team



City Of Las Vegas Recreation
Department
(YABL) Young American Basketball
League Registration Form

Name _____ Address _____

Phone# _____ City _____ State _____ Zip _____

D.O.B. _____ Grade _____ Name of School _____

Age _____ Sex _____ Shirt Size Youth or Adult S M L XL XXL

Parent/Guardian Name (Please Print) _____

Work Phone# _____ Home# _____ Cell# _____

Emergency Contact _____ Phone# _____

Physician _____ Phone# _____

Medical Insurance Carrier _____

Policy # _____ Date of Last Physical _____ (Submit copy)

City of Las Vegas Emergency Medical Authorization Form

Purpose: To enable parents or guardians to AUTHORIZE emergency treatment for children who become ill or injured while under program authority, when parents cannot be contacted. Upon completion parents must return this form to the Abe Montoya Recreation Center. The original form and any copies thereof may be used to identify the medical options of the undersigned parent. This consent is valid for child's years of K-12.

Participant's Full Name

Address

City

Zip

D.O.B

Telephone

Mother's Full Name

Daytime Phone

Father's Full Name

Daytime Phone

GRANTING CONSENT

In case of an emergency involving my child where I cannot be reached, I hereby give consent to transport my child to the following medical care providers and hospital, I give any reasonable and customary medical and health care deemed necessary.

Primary Physician

Telephone

Primary Dentist

Telephone

If for any reason the above listed medical care providers or hospital cannot be reached. I authorize appropriate transport and medical care of my child to any appropriate medical care provider, hospital and/or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concur.

Nothing in this section shall be constructed to impose liability on any city official or city employee whom in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care.

Date

I/We, named below do hereby agree to release, hold harmless, and forever give up any claim against the City Of Las Vegas Recreation Department or any of its agents or representatives, that may arise in the future, for damages on account of bodily injury or property damages arising in any manner out of participation in the Abe Montoya Recreation Centers programs.

I/We, understand that should any injury occur during participation in the aforementioned programs, the City Of Las Vegas, its agents, and or its representatives cannot be held responsible; and I/We, understand that by signing this form all legal rights to hold the City Of Las Vegas Recreation Department or any of its agents or representatives responsible are waived.

Parent/Guardian Signature

Date

****The City Of Las Vegas Recreation Department does not have the ability to handle special needs children, if your child has special needs they will need to be accompanied by someone who is able to care for their individual needs.**

Parent/Guardian Signature

Date

Parents, Participants and Coaches

All participants must follow the rules and regulations of the Abe Montoya Recreation Programs. If a participant breaks the rules, He or She may be suspended from any of the programs.

Parent/Guardian Signature

Date

MEDICAL HISTORY

Facts concerning the child's medical history to which a physician should be alerted.

All information obtained is considered confidential, except to medical provider.

Please indicate if student has had, or is currently under treatment for any of the following conditions:

Asthma

Diabetes

Seizures

Heart Problems

Hepatitis

Migraine Headaches

Bleeding disorders

High Blood Pressure

Ear Problems

Emotional Problems

Tetanus (date) _____

Infectious diseases

Meningitis

Muscular Weakness

Allergies

Reactions to medicines

Hospitalized for serious illness, surgery, or accidents? Explain

Use of contact lenses?

Yes

No

Long term medications? _____

Have you ever been informed of the need to be on an antibiotic therapy prior to dental treatment? Yes No

Please add any problems not listed: _____

Fill out or attach a copy of immunization record:

DPT	#1 _____	#2 _____	#3 _____	#4 _____	#5 _____
Polio	#1 _____	#2 _____	#3 _____		
MMR	#1 _____	#2 _____			
Hepatitis	#1 _____	#2 _____	#3 _____		
HIB	#1 _____	#2 _____	#3 _____	#4 _____	

**Abe Montoya Recreation Center
Youth Sports Physical Form**

Name

Age

Program

Head

Chest

Heart

Abdomen

Extremities

Weight

Height

Blood Pressure

Vision

Physicians Signature

Date

Parents Signature

Date